pathophysiology of PG. TNF-α antagonists may represent an alternative to cyclosporine in steroid-refractory PG.

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Recent dermatology visit is associated with thinner Breslow depth nodular melanomas

To the Editor: Nodular melanomas (NMs) account for 10% of melanomas, but account for >50% of deep melanomas (>2 mm).[1] The goal of this study is to characterize health care use patterns of individuals with NM compared with other types of melanomas in a US population. We evaluated melanomas diagnosed between September 1996 and December 2015 in the Veterans Affairs Miami Health Care System.

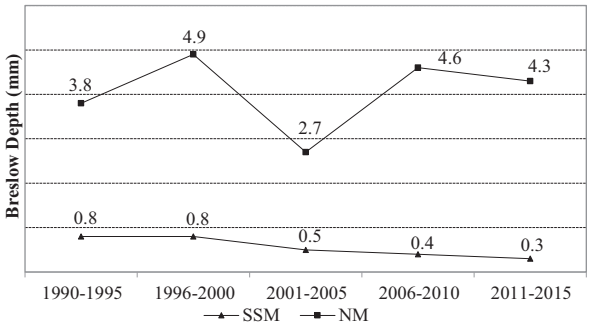

Fig 1. Average Breslow thickness of nodular melanoma (NM) and superficial spreading melanoma (SSM) over time. NM had an average Breslow thickness of 3.8 mm at diagnosis in 1996 compared with 4.3 mm in 2015 ($P = .84$). SSM had an average Breslow thickness of 0.8 mm at diagnosis in 1996 compared with 0.3 mm in 2015 ($P = .01$).

We found no significant change in average Breslow thickness of NM over time (3.8 mm in 1996 vs 4.3 mm in 2015, P trend = .84) while the detection for superficial spreading melanomas had improved significantly (0.8 mm in 1996 vs 0.3 mm in 2015, P trend = .01; Fig 1).

The percentage of patients with NM who had seen a primary care physician or a dermatologist in the 6 months preceding the diagnosis was significantly lower than for those with other types of melanomas (primary care physician, $P = .05$; dermatologist, $P = .03$, χ^2); patients who had seen a dermatologist in the 6 months preceding their diagnosis had significantly thinner NMs than those that had not been seen (1.81 mm vs 3.85 mm, $P = .006$). Individuals with NM were significantly less likely to have had age-appropriate colonoscopy screening compared with those with other types of melanomas (47.0% for NM vs 73.7% for melanoma—other, $P < .01$, χ^2; Table I).

This study revealed several important findings. First, the detection of NM has not improved over time in this group of predominantly older, white men. Second, patients who develop NM are more likely to be lacking in skin-specific and general preventative care. Third, routine dermatology contact resulted in significantly thinner NMs at diagnosis.

In this population of US veterans with standardized health care, institutional factors such as differential access to Veterans Affairs care is less likely a significant contributor in accounting for the difference between individuals with NM versus other types of melanomas. Personal factors, such as a general low perceived need for preventive care and a lack of preventive habits (eg, sunscreen use, self-examinations) may play a greater role accounting for overrepresentation of health care underusers in the NM group. Future study should

Table I. Clinical and demographic features of patients diagnosed with nodular melanoma and melanoma—other

	Nodular melanoma (n = 60)	Melanoma—other (n = 265)	*P* value
Men, %	98.0	96.9	.65
Race, white, %	94.9	94.8	.97
Average age, y	70	67	.03
Average Breslow thickness, mm	3.9*	0.76	<.01
Lesion identified by patient, %	38.5	22.2	.01
VA primary care physician visit in preceding 6 months, %	85.0	92.9	.05
VA dermatology visit in preceding 6 months, %	20.0	34.2	.03
Age-appropriate colonoscopy screening, %	47.0	73.7	<.01
History of skin cancer, %	38.9	51.3	.08
History of other noncutaneous malignancy, %	20.0	34.0	.04

VA, Veterans Affairs.
*Seen by dermatology in preceding 6 months: yes, 1.81 mm; no, 3.85 mm ($P = .006$).

evaluate barriers to care in this and the general population.

Another key finding of the present study is that routine visit to a dermatologist is associated with early detection of NMs at a more survivable stage of <2 mm.[2] A previous study also found that individuals who had a skin check in the past 3 years had thinner NMs.[3] Individuals with thinner NMs are also more likely to report "change in color" and "irregular shape" in their NMs.[3] Taken together, these results suggest that close contact with a dermatologist may result in both institutional-based protective factors (eg, prompt detection by obtaining a biopsy specimen) and individual-based protective factors (eg, routine at-home self-examination and attentiveness to melanoma-specific signs) that can be lifesaving.

Routine contact with a dermatologist can be lifesaving for individuals who are at risk for NM. The results of the present study emphasize the importance of preventative care.

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The Institutional Review Board at Veterans Affairs Miami Health Care System approved this study (protocol 4987.04). Presented in abstract form at the American Academy of Dermatology Annual Meeting, March 3-7, 2017, Orlando, Florida.

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Effect of postinjection facial exercise on time of onset of botulinum toxin for glabella and forehead wrinkles: A randomized, controlled, crossover clinical trial

To the Editor: Many clinicians recommend exercising treated muscles for 4 hours after botulinum toxin injection in order to enhance cellular uptake; however, no data exist in the literature to substantiate the physiology or the clinical efficacy of this method.[1] The purpose of this study was to determine whether facial muscle exercises after injection of botulinum toxin into forehead and glabella rhytids results in